1. Subject. Aviation Medicine Standard Operating Procedure (SOP).

2. Proponent. Flight Surgeon.

3. References.

a. AR 1-201, Army Inspection Policy, 4 Apr 08
b. AR 40-3, Medical, Dental, and Veterinary Care, 22 Feb 08
c. AR 40-8, Temporary Flying Restrictions Due to Exogenous Factors, 16 May 07
d. AR 40-66, Medical Record Administration and Health Care Documentation, 17 Jun 08
e. AR 40-501, Standards of Medical Fitness, 14 Dec 07
f. AR 95-1, Flight Regulations, 3 Feb 06
g. AR 220-1, Unit Status Report, 19 Dec 06
h. AR 340-21, The Army Privacy Program, 5 Jul 85
i. AR 385-10, The Army Safety Program, 23 Aug 07
k. AR 600-105, Aviation Service of Rated Army Officers, 15 Dec 94
l. AR 600-106, Flying Status for Nonrated Army Aviation Personnel, 8 Dec 98
m. AR 616-110, Selection, Training, Utilization, and Career Guidance for Army Medical Corps Officers as Flight Surgeons, 19 Mar 86
n. DA PAM 385-90, Army Aviation Accident Prevention, 28 Aug 07
o. FM 3-04.301, Aeromedical Training for Flight Personel, 6 Apr 07
p. FM 3-04.508, Aviation Life Support System Maintenance Management and Training Progam, April 2004
q. FORSCOM ARMS Guide, Annex J, Aviation Medicine, 1 Oct 08
r. TC 8-800, Medical Education Demonstration of Individual Competence, Feb 07

4. Purpose. This annex establishes a Standard Operating Procedure (SOP) for the operation and conduct of the Aviation Medicine Program for the Insert Your Unit Here. It provides guidelines for medical care for both aviation and non-aviation personnel. It further describes the command factors non-clinical administrative and clinical responsibilities of the Unit Flight Surgeon (or Aviation Physician Assistant unless specified), including administration of routine medical care for aviators, crew, and non-flight personnel, flying duty medical examinations, and non-clinical duties.

5. Responsibilities and Duties. The Unit Commander has overall responsibility for the conduct of the Aviation Medicine Program. Operation and administrative responsibility for the program will be delegated to the Battalion Flight Surgeon at the discretion of the Commander.

6. Mission Statement. The mission of the Aviation Medicine Program is to provide medical support, both non-clinical and clinical, to the Insert Your Unit Here population to ensure individual health, flying safety, and successful mission completion.

7. Non-clinical Responsibilities. (Command Factors)

a. The Flight Surgeon (FS)/Aeromedical Physician Assistant (APA) will serve as a special staff officer with several functions.

(1) The FS/APA will be the principal advisor to the Commander on all aeromedical issues.

b. Aircrew Training Program (ATP). The Flight Surgeon/Aeromedical Physician Assistant will be incorporated into the Commander's Aircrew Training Program. The FS/APA assigned to aviation medicine duties will participate in frequent flights in Army aircraft. Flying in Army unit aircraft is an essential part of a successful aviation medicine program. The FS/APA will see the Flight Operations Officer to ensure the following:

(1) Be on flight status with valid orders issued by the appropriate agency.

(2) Will meet the minimum flying hour requirements by conducting frequent flight line visits. S/He will participate in frequent and regular aerial flights in all types of aircraft of the supported units as required by AR 600-105, AR 600-106 and DA PAM 385-90. S/He will observe launch and recovery operations of ATC personnel as well.

(3) Incorporated into the local and supported units' Reading Files.

c. Flight Operations: Individual Flight Records Folders. The FS/APA will work closely with the Flight Operations Officer to ensure that all of the following aeromedical aspects are accomplished.

(1) Individual Flight Records Folders (or ATS Controller Records) contain the required DA Forms 4186 (medical clearance for flying or medical restriction from flying), and they are completed correctly.

(2) Crew members' individual flight records folders contain applicable medical waiver approval letters.

(3) Extensions (one time, one calendar month) are granted for flight physicals prior to the expiration date of the current flight physical.

(4) Procedures in place to ensure crew members and ATC personnel are not performing aviation duties with expired flight physicals or extensions.

(5) Non-operational aviators are completing annual flight physicals.

(6) Department of the Army Civilian (DAC) pilots, contract pilots, civilian non-rated crew members or non-crew members, contract non-rated crew members and non-crew members, civilian Air Traffic Control (ATC) personnel, and Wage Grade 11(WG-11) personnel are maintaining valid flight physicals [Army Flying Duty Medical Examinations (FDMEs), Flying Duty Health Screens (FDHSs) or Federal Aviation Administration (FAA) Medical Certificates].

(7) Maintain a flight physical tracking mechanism to track flight physicals from initiation through posting of the final disposition stamped copy from AAMA in the health records.

(8) Monitor and provide input to the Commander on the fighter management (crew rest) program.

d. Automatic Grounding Procedures.

(1) The FS/APA will establish procedures whereby aircrew members are automatically grounded when treated in an emergency center or specialty clinic. All aircrew members seen in an emergency center or specialty clinic are automatically considered grounded, and will report to the Battalion Flight Surgeon/Aeromedical Physician Assistant the next duty day to sick call for evaluation and issuance of the Down-Slip. After an aeromedical evaluation, the FS/APA will determine length of temporary grounding and recommend DNIF (duties not to include flying) to the commander on the DA Form 4186 (Medical Recommendation for Flying Duty). Upon completion of the temporary medical suspension the crew member will return to the fight surgeon's office for reevaluation and issuance of an Up-Slip FFD (Full Flying Duties) before returning to flight duty.

Note: The unit commander is the approving authority for the DA Form 4186.

e. Pre-Accident Plan/Safety Council/Aviation Accident Prevention Surveys. The FS/APA will work closely with the Safety Officer/Safety Council to ensure that all of the following aeromedical safety aspects are accomplished.

(1) The medical portion of the pre-accident plan is adequate and reviewed annually. S/He will ensure a phone-check is completed annually.

(2) Participate actively in aviation safety and standardization meetings and be a member of the unit Safety Council.

(3) Conduct aviation accident prevention surveys (AAPS) in the area of aviation medicine every six months for active duty and annually for National Guard and Reserve and keep them on file for at least five years. S/He will also ensure that any hazards found will be listed on the unit's hazard-tracking system.

(4) A Flight Surgeon will participate in aircraft accident investigations, serving as a board member when indicated. The flight surgeon makes recommendations to improve human factors, crashworthiness, and survival features of the aircraft. While assigned to an aircraft accident board, the Flight Surgeon will be relieved of all other duties for the duration of the board. An APA may not replace the Flight Surgeon in this role.

(5) The Flight Surgeon (an APA may not replace the Flight Surgeon in this role) will serve as a member of Flight Evaluation Boards when indicated.

f. Aviation Life Support Equipment (ALSE). The FS/APA will work closely with the ALSE personnel to ensure that all the following aeromedical aspects are accomplished.

(1) Visit the ALSE shop regularly (quarterly visits to monitor the ALSE program, with at least semi-annual inspections as part of AAPS). FS/APA will document quarterly visits on the

aviation medicine ALSE Checklist, or memorandum for record, and ALSE visitor log. Maintain a copy of the semi-annual FS/APA inspections as part of the AAPS for aviation medicine. FS/APA will ensure the ALSE shop receives a copy of all FS/APA ALSE inspections.

(2) Actively monitor the fitting and use of aviation life support equipment.

(3) Identify any medical issues that physically or mentally impede the aircrew member from safely undergoing his tasks while wearing survival gear.

(4) Assist the ALSE shop with Class VIII support and will periodically review the operational load of Class VIII. (ARNG requires a formulary)

(5) During periodic visits to the ALSE shop, monitors the ALSE shop and ALSE personnel to ensure proper cleanliness and personal hygiene.

(6) Monitor the physiological training of aircrew personnel, to include the medical aspects of survival training of aircrew personnel.

(7) Review and make recommendations to the Commander for improvement of human factors compatibility, crashworthiness, aviation life-support equipment (ALSE) program, and the survival features of the aircraft.

(8) Ensure that the FS/APA responsibilities are addressed in the Aviation Life-Support Equipment SOP.

g. Aeromedical Training.

(1) Unit Training. The unit commander must develop an aeromedical training program that meets the unit's specific needs as part of the Aircrew Training Program governed by TC 1-210. The unit's mission and its wide range of operations are the important factors for the commanders to consider in developing an aeromedical training program. The program must include the various aeromedical factors that affect crew members' performance in different environments, during flight maneuvers, and while wearing protective gear. The unit aeromedical training program will contain, as a minimum, the continuous training and special training described below. Because of the medical and technical nature of the aeromedical training program, the unit commander will involve the assigned or supporting flight surgeon in developing the program. The FS/APA will provide input into all aspects of unit aviation plans, operations, and training.

(2) Continuous Training. The requirement for continuous training applies to all aircrew members in operational flying positions. The unit will conduct the program of instruction at least once a year. The following subjects are the minimum training requirements. For more information on this and other Aeromedical Training, accessed on the web at the USASAM AKO or USASAM public site links below. https://www.us.army.mil/suite/portal/index.jsp, http://usasam.amedd.army.mil/index/index.htm

(1) Altitude Physiology
(2) Spatial Disorientation
(3) Aviation Protective Equipment
(4) Stress, Fatigue, and Exogenous Factors

(3) Mission Considerations. The unit Commander must evaluate the missions of the unit to incorporate mission considerations into the aeromedical training program of instruction. The analysis will include as a minimum the following. The FS/APA will help identify the aeromedical factors present during the various flight conditions and their effect on aircrews' performance. The FS/APA and unit Commander will conduct this assessment at least annually and will publish training requirements in the unit Commander's Annual Training Guidance, and will ensure established programs of instruction are annotated in the Battalion's Training Schedule for approved blocks of training time.

(1) Combat mission
(2) Installation support mission
(3) Contingency mission
(4) Geographic and climatic considerations
(5) Programmed training activities

(4) Hypobaric Refresher Training for fixed or rotary wing- aircrew members, who fly in pressurized aircraft or in aircraft operating above 10,000 feet with supplemental oxygen must complete aeromedical refresher training to include participation in a hypobaric chamber (Type IV Profile) every five years. Aircrew members who fly in pressurized aircraft must also complete a rapid decompression. This training will be conducted by an approved physiological training unit. Aircrew members with 240 months of Total Operational Flying Duty Credit (TOFDC) and four successful altitude chamber iterations must complete classroom training requirements but are exempt from the altitude chamber and rapid decompression practical exercise requirements.

h. FS/APA Medical Support/Training of Unit Medical Section Personnel. The FS/APA will ensure that the following medical support and training of unit medical personnel is accomplished.

(1) Provide medical representation in education and training of aviation personnel regarding aeromedical aspects of flight, health maintenance, and operational medicine.

(2) Participate in the Battalion Aviation Mission Planning Process.

(3) Participate in the planning and execution of unit field training exercises and field problems.

(4) Supervision and coordination of the training for all noncommissioned and enlisted medical personnel assigned or attached to the battalion.

(a) Medical Education and Demonstration of Individual Competence (MEDIC) shall be administered annually via successful completion of Table 8 (Validation) of MEDIC with a minimum of a six-month separation between validation tests for assigned medics.

(b) National Registry Emergency Medical Technician (NREMT) recertification shall be accomplished every two years.

I. FS/APA Support of Medical Company Air Ambulance. (MEDEVAC Only) The FS/APA will work closely with the Medical Company Air Ambulance (AA) to ensure that the following air ambulance requirements are established.

(1) Function as medical technical advisor to the local air ambulance unit commander.

(2) Establish, in writing, a set of local medical treatment protocols for air ambulance personnel (Flight Medics). These protocols shall be reviewed at least annually.

(3) Provide and participate in the medical training of air ambulance personnel.

(4) Review reports of medical evacuation (run sheets) for appropriateness of the mission and care given. Provide feedback to the flight medics.

(5) Ensure airworthiness releases have been issued for all medical equipment taken aboard medical evacuation aircraft.

8. The Aviation Medicine Clinical Care Program.

The Aviation Medicine Clinical Care Program consists of primary care, health record maintenance, flying duty medical examinations, preventive medicine and educational programs.

a. Primary Care.

(1) Provision of clinical care for battalion soldiers.

(a) Sick Call. Routine Sick Call will be provided @_____during garrison operations. Sick Call hours are from 0630-UTC. Emergency care during duty hours is available at local hospitals or by contacting the Battalion FS/APA.

(b) Non-urgent Care. The FS/APA will make every attempt to see soldiers during Sick Call; however, appointments should be made for detailed evaluations to include flight physicals.

(2) Supervision of non-physician health-care providers.

(a) The Flight Surgeon will be responsible for the supervision and training of any other health care provider assisting in the care of aviators and their family members.

(b) Aeromedical Physician Assistants, registered nurses, licensed practical nurses, MOS 68W series medics, and physical examination technicians are considered non-physician health care providers.

(3) Deployment and Readiness. The FS/APA will periodically review battalion immunization status, survival and physiological training, required aviation medicine training and combat lifesaver/first aid training. S/He will keep commanders informed about the health of their commands.

(a) S/He will ensure that aircrew members who fly in pressurized aircraft or in aircraft assigned or attached to the BN that routinely exceed 10,000 ft MSL receive hypobaric training per FM 3-04.301 Para 1-3.

b. Health Record Maintenance.

(1) Individual Health Records (HREC) will be maintained in the custody of the Aviation Medicine Clinic, Medical Treatment Facility or maintained locally by an appointed Health Records Custodian.

(2) To ensure security and confidentiality of HRECs, access is restricted as described in the following: The Health Records custodian will be appointed on orders and trained in accordance with HIPAA/PHI. Personal Health Information is to be considered as For Official Use Only by all personnel who have contact with it. For this reason even the individuals listed below will have access granted on a need-to-know basis only.

(a) Medical Personnel. AMEDD personnel are allowed direct access to HREC for purposes of diagnosis, treatment, and the prevention of medical and dental conditions.

(b) Military members. Upon request by the service member, copies of the HREC will be provided.

(c) Inspectors. Personnel inspecting the unit, the MTF or DENTAC may have direct access to the HREC. All inspectors must respect the confidentiality of the HRECs.

(d) Mortuary Affairs. Personnel are allowed direct access to the HREC of personnel killed or missing in action. They may extract copies of records needed to perform their mission.

(e) Other Personnel. Other non-medical personnel may need access to HRECs for official reasons. These personnel include unit commander, inspectors general, Judge Advocate General Corps personnel, military personnel officers, or military criminal investigators. These personnel must make a written request through the unit and MEDCOM who will determine what information will be supplied.

(f) In general, for official use other than patient care, only enough information will be provided to satisfy the request.

c. Flying Duty Medical Examinations.

(1) The Flight Surgeon/Aeromedical Physician Assistant will perform comprehensive flying duty medical examinations (FDMEs) and flight duty health screens (FDHS) of Insert your unit aircrew members, personnel selected for aviation training, aviation maintenance training, aviation medicine training, or air traffic control training.

(2) The aircrew member is responsible for maintaining a current medical certification—DA Form 4186, Medical Recommendation for Flying Duty. In order to have a current DA Form 4186, the aircrew member **MUST** maintain a current and qualified FDME/FDHS. The following Army regulations and publications address the importance of the FDME/FDHS and place the responsibility squarely on the aircrew member.

- **AR 600-105** is applicable to **rated** aircrew (pilots and flight surgeons) and stipulates that Army officers who enter aviation service must continually maintain medical and professional standards. Failure to maintain medical certification is reason to convene a Flying Evaluation Board (FEB). All aviators regardless of component or whether or not assigned to operational flying duties must maintain certification for flying duty through timely completion of the FDME.

- **AR 600-106** covers **non-rated** aircrew (flight medics, aeromedical psychologists, dentists, optometrists, flight engineers, crew chiefs, stewards, et al) and has similar stipulations.

- **FM 3-04. 300** covers flight operations procedures and mandates that individuals who do not have a current flight physical or flight physical extension will be suspended from flying status until medical clearance is given.

(3) The FS/APA will perform Comprehensive Flying Duty Medical Examinations (FDME) on unit personnel to include non-operational aviators and other aviation personnel, every five years as prescribed by AR 40-501. Comprehensive FDMEs will be performed every five years between the ages of 20 and 50 and annually thereafter. The five-year period will be based on the year of the initial FDME or the date of the last Comprehensive FDME. The comprehensive FDME will be performed within **3 months before the end of the birth month in the year it is due.** The Flying Duty Health Screen (FDHS-formerly the interim FDME) will be performed in the interim years. The FS will request consultation with specialists of the Aeromedical Activity when necessary. The Flight Surgeon will perform other health assessments as necessary, to include Chapter, ETS, Airborne, Ranger, High-Altitude Low-Opening (HALO), Survival, Evasion, Resistance Escape Training (SERE), Confinement, and periodic physical examinations.

(4) All personnel will report to the FS/APA while in-processing to receive a report to new duty station DA Form 4186. Aircrew members are also required a report to new duty station DA Form 4186 when they change companies within a Battalion or change to a new Battalion. The crew member is now in a new ATP and the aircrew member's new commander must approve their upslip to fly in his/her ATP. In addition, all personnel on flight status must go to

the aid station after an Emergency Room visit or upon receiving medication from a non-flight surgeon to ensure its suitability for flight operations. All flight status personnel will consider themselves grounded from the time of the visit or medication until seen by the FS/APA.

(a) Factors to consider and appropriate medical restrictions to flying activities include, but are not limited to—

(1) Medication use. Use of all medications will be with the knowledge of a flight surgeon or APA. Aircrew members taking any medications will be restricted from flying duties until convalescence and/or rehabilitation is completed unless cleared for flying duties by a flight surgeon or APA. Self-medication is permitted only in accordance with the over-the-counter medication aeromedical policy letter (APL). The most recent APL is available at https://aamaweb.usaama.rucker.amedd.army.mil/index.html.en.

(2) Anesthesia. Aircrew will be restricted from flying duty for 48 hours after general, spinal, or epidural anesthesia and for a minimum of 12 hours after local or regional anesthesia, to include dental.

(3) Use of dietary supplements, herbal and dietary aids, and performance enhancers. All supplements, herbal and dietary aids and preparations, and performance enhancers are prohibited unless cleared by the flight surgeon or APA in consultation with applicable APLs.

(4) Alcohol. Aircrew will not perform aviation duties for a minimum of 12 hours after the last drink consumed and until no residual effects remain.
d. Immunizations. Medical restriction from flying duty will be for a minimum period of 12 hours following any immunization. If any type of reaction occurs, local or systemic, the aviator remains restricted from flying duties until cleared by a flight surgeon or APA.

(5) O-chlorobenzylmalononitrile (CS)/tear gas exposure. Aircrew will not be restricted from flying duty after CS exposure as long as there are no residual systemic effects (for example, coughing, wheezing, or shortness of breath), and all local effects (for example, tearing, eye pain, skin discomfort) have resolved and any contaminated clothing or aviation life support equipment has either been exchanged or decontaminated. Exposure to any other nuclear, biologic, or chemical agent or stimulant will require clearance from a flight surgeon or APA before flight duties can be resumed.

(6) Blood or plasma donation. Aircrew members will not be regular (more than two times per year) blood or plasma donors. Following blood donation (200 cc or more), aircrew members will be restricted from flying duty for a period of 72 hours. Following plasma donation, aircrew members will be restricted from flying duty for a period of 24 hours. Bone marrow donors will be cleared by a flight surgeon or APA prior to returning to flying duties.

(7) Decompression experience/hypobaric chamber runs. Any adverse reaction, barotraumas or decompression sickness resulting from a decompression experience, requires restriction from flying duties until cleared by a flight surgeon or APA. Flight personnel will not perform high altitude flight duties for 24 hours after exposure to hypobaric chamber runs in excess of 25,000 feet. They may perform flying duties during the initial 24 hours following a decompression experience in aircraft where cabin altitude does not exceed 10,000 feet. Heavy exercise or work may mimic the signs and symptoms of decompression sickness and are discouraged in the 24-hour period following a decompression experience.

(8) Diving and hyperbaric exposure. The incidence of decompression sickness during flight is considerably increased after exposure to any environment above one atmosphere of pressure, such as self-contained underwater breathing apparatus (SCUBA) diving. Aircrew members will not fly or perform low pressure altitude chamber flights within 24 hours following SCUBA diving, compressed air dives, or hyperbaric chamber exposures. When urgent operational requirement dictates, aviation personnel may fly within 24 hours of SCUBA diving provided no symptoms of decompression sickness have developed and the aircrew members are examined and cleared to perform flying duties by a flight surgeon or APA trained in diving medicine or a diving medicine officer. Decompression sickness, resulting from diving or other hyperbaric exposure, requires a restriction from flying duties by a flight surgeon or APA.

(9) Tobacco. Smoking and use of tobacco products degrade physical performance, including vision. Aircrew members are discouraged from smoking and use of tobacco products at all times.

(10) Strenuous physical activities. Strenuous training events, sporting activities, or work may adversely affect the ability of aircrew members to perform their respective flight tasks safely. Flight surgeons and APAs must be able to recognize when this occurs, or is likely to occur, and be prepared to advise commanders as to any restrictions applicable either to units or individuals. Examples of strenuous training events or work are found in, but not limited to, activities listed in FM 21–10 and GTA 05–08–012, Individual Safety Card.

(11) Simulator sickness. Under ordinary circumstances, restrictions on actual flight are not required after flight in a simulator. Simulator sickness can occur in any aircrew, regardless of experience level. Aircrew exhibiting symptoms of simulator sickness will be restricted from actual flight for 12 hours after full resolution of symptoms.

(12) Centrifuge runs. Centrifuge runs may adversely affect aircrew due to the physical strain of high G-load and sensory disturbance. Aircrews are restricted from all flying duties for a minimum of 6 hours after centrifuge runs and until no residual effects remain.

(b) In cases where a temporary medical suspension is expected to exceed 365 days, the Flight Surgeon will consider medical termination from aviation service per AR 40-501.

(c) All aircrew members must be medically cleared by the Flight Surgeon after a temporary medical disqualification or aircraft mishap.

(4) The Flight Surgeon (FS) will be responsible for monitoring all FDME/FDHSs performed by Aeromedical Physician Assistants or other health care providers.

(a) FS/APA can issue a signed DA Form 4186 as an up-slip.

(5) The FS/APA will maintain a suspense file on all upcoming and pending flying duty medical examinations. The FS/APA should provide the commanders a list of everyone who is in their birth month window (3 months). Provided commanders an updated lists every command and staff to ensure everyone was doing their FDME/FDHSs before the end of their birth month. This technique also forces them to get the physical started early and limits the need for extensions.

(a) The local flight facility will provide a by-name list of crew members whose birth month has started the 1st of each month. If this is not done then the FS/APA is responsible for ensuring notification of each crew member to ensure the FDME/FDHS is scheduled.

(b) The FS/APA will provide to the local flight facility and Commander on the last duty day of the month a by-name list of crew members who fail to accomplish their FDME/FDHS or obtain a one calendar month extension by the last duty day of the month.

(c) Unless a one calendar month extension is requested and granted prior to the last day of any soldier's (enlisted or officer) birth month the flight surgeon will initiate a DNIF 4186 (temporary grounding slip) and notify the Commander and local flight facility that the soldier has not completed his/her FDME/FDHS. This can be done the 1st day of the month following the birth month.

(d) Rated crew members should be recommended for consideration by the Commander for a non-medical disqualification and Flight Evaluation Board once a FDME/FDHS or 4186 has expired if an extension has not been granted.

(e) Non-rated crew members will be recommended to the Commander for suspension of flight pay and be administratively suspended by operations for overdue FDME/FDHSs.

(f) If a crew member receives a partial 'deployment physical' while deployed they must complete the FDME/FDHS within 90 days of redeployment.

(6) Preparation and proper disposition of indicated Aeromedical Summaries will be the responsibility of the FS/APA.

(a) All waiver recommendations and approval letters shall be copied to the individuals IFRF and HREC.

(7) The FS/APA should set up a system that requires flight operations to sign for the 4186s from the flight surgeon's office. The flight surgeon's office should maintain a copy of the document listing the 4186s flight operations signed for.

(a) The flight surgeon will track FDME/FDHSs from initiation until final posting in the individual Health Records, individual Flight Records, and unit records.

d. Preventive Medicine and Educational Program.

(1) A continuing crew member education program will be supervised by the FS/APA, with emphasis on physiological effects of flight, self-medication, alcohol and tobacco use, physical fitness, and first aid. The FS/APA works in conjunction with the standards shop to supervise the continuous training requirement of all aircrew members. Every effort will be made to coordinate this training through the local Flight Facility and with other co-located aviation units.

(2) The FS/APA will coordinate with the ALSE shop at least once yearly to determine the yearly training plan for survival instruction.

(3) Medical education in the form of initial and re-certifying Combat Lifesaver training will be made available to all battalion personnel on a periodic basis.

(4) Non-Prescription Medications.

a. Self–medication by anyone on flight status is prohibited by AR 40-8. The following medications can, however, be used for short periods of time, when a FS/APA is not immediately available.

Antacids
Artificial Tears
Aspirin
Tylenol
Motrin
Cough Medicine with Guafensin *only* (no antihistamines or dextromethorphan)
Kaopectate
Sudafed (30mg over the counter dose)
Nasal Saline sprays
Afrin
Metamucil
Throat Lozenges

b. The FS/APA must be made aware of the need for repeated usage of any of the above medications, as it may represent a more serious condition. Multivitamins used in normal supplemental doses are approved for use, however any other homeopathic supplement, ergogenic aid (i.e. "Rip Fuel"), any other substance taken to have a physiological (i.e. "Creatine") or mood stabilizing effect (i.e. "St. John's Wort") are *not* approved for use by personnel on flight status. Note: Flight personnel can use creatine with the approval of the FS/APA.

9. Aviation Resource Management Survey (ARMS) Aviation Medicine.

a. Responsibilities. The Flight Surgeon, APA or Aviation Medicine representative manages the unit's Aviation Medicine Program to ensure that all aircrew members are trained and fit for duty IAW AR 600-105, AR 616-110, AR 95-1, PAM 385-90, AR 40-3, AR 40-501, and the unit's Standing Operating Procedures.

b. ARMS Survey Cycle. Normally, aviation units/organizations will undergo an ARMS every 18-24 months. The ARMS is a snap shot in time of the unit's readiness posture. First, the FS/APA should acquire the survey results of the previous ARMS. Ensure all noted deficiencies have been corrected. The ARMS Checklist and ARMS Guide will be valuable sources to obtain a good sense of where the Aviation Medicine Program is relative to the many Army Regulations that govern that program.

c. Aviation Medicine Program Surveyor. Time is critical during the survey. There is usually little time for surveyor and Flight Surgeon interface due to survey schedules and reporting deadlines. Bottom line is that if you cannot produce documentation showing the required training, appointment or action, then the action was not completed. If you have questions, don't wait to ask. Contact the surveyor at USASAM via the USASAM homepage on AKO (AKO Home > MACOMS > MEDCOM > USASAM) or by phone (334.255.7201). Due to the high paced FORSCOM ARMS schedule and low number of Aviation Medicine surveyors, the best method to contact the Aviation Medicine surveyor is via e-mail.

d. ARMS Preparation. The FS/APA should.

(1) Acquire a copy of the FORSCOM Commander's Guide and ensure he/she has the current version. It changes every October.

(2) Take the Aviation Medicine portion and answer all the questions. Prepare and file your supporting documentation in the order of the questions in the Commander's Guide.

(3) He/She does not have to pull everything out of file folders, but it should be organized and available. For example, if the Health Records are maintained at the company or at a Medical Treatment Facility.

(4) Brief all necessary personnel that the records will be surveyed.

(5) Prepare a memorandum signed by the commander authorizing the ARMS Aviation Medicine surveyor to review the Health Records.

Note: To a certain extent the surveyor's schedule will accommodate the unit's mission schedule. The exact details of the schedule will be coordinated between the surveyor and the Flight Surgeon at the in-brief.

(6) **Have his/her continuity books/files ready.** A prepared FS/APA who knows what will be looked at, when, where, and why is a good start. All questions contained in the ARMS Commander's Guide are based on an Army standard and supported by a regulatory reference. Techniques to improve a program or another way of doing something are suggestions or recommendations only. The more prepared the FS/APA is for the survey, the more time the surveyor can spend on assisting and sharing knowledge.

e. ARMS documentation needed.

(1) MTOE/TDA and unit manning roster.

(2) FS/APA's flight orders, -12 print out for the last 12 months.

(3) Unit's Aeromedical Continuation Training POI and sign in rosters.

(4) Safety Council appointment orders for the FS/APA and meeting minutes.

(5) Previous Aviation Accident Prevention Surveys in the area of Aviation Medicine to include the last five years and Hazard Logs.

(6) Unit SOP, specifically the sections referring the Aviation Medicine.

(7) Aircrew member roster with last name, rank and last four of SSN to include non-operational aviators.

(8) Unit Pre-Accident Plan.

(9) Individual Flight Records Folders (suggest leaving these in Flight Ops).

(10) Health Records will be reviewed in the unit area or at the post's MTF. If they are located across the state, unit will have aircrew member Health Records brought to the unit area for the survey.

Note: These are the minimum documents/files required. The surveyor may ask for additional documentation in order to clarify related issues.

f. Aviation Medicine ARMS.

(1) Normally the FORSCOM ARMS surveyor will meet with the unit POC (preferably the Flight Surgeon or APA, but at least a unit representative who is familiar with the ARMS Checklist) during the scheduled in-brief to arrange the conduct of the ARMS.

(2) After the introduction, the surveyor and unit representative will proceed to the decided upon work area (usually Flight Operations first) and commence the survey. The surveyor and unit representative will initially spend some time discussing informal questions related to the unit and the survey. The surveyor will be interested in how long the FS/APA has been assigned, his/her background, how his/her units are arrayed, and past and future deployment plans.

(3) The surveyor will use the published checklist for the survey. There will be no surprise questions. The FS/APA should feel free to ask questions and seek clarification on areas that may be unclear prior to the surveyor departing the area.

(4) The surveyor will provide the FS/APA with a detailed verbal summary of his assessment prior to departing the area. Remember, the final survey assessment is up to the discretion of the ARMS Team Chief.

(5) There may be some areas or issues that will require a little closer investigating for final results, but the FS/APA will have a good idea of the Aviation Medicine Program's status prior to the surveyor's departure.

(6) At the close of the survey (during the unit final out-brief), the ARMS Team Chief will provide your Commanders with a comprehensive report that outlines areas requiring improvement, recommended program changes, and any commendable areas.

(7) The FS/APA should ensure he/she receives a copy of the report and that all findings are corrected as required. The FS/APA is encouraged to provide feedback to FORSCOM or USASAM upon completion of the survey.